MEDICARE COMPLIANCE

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The Medicare Secondary Payer Statute (MSP)

As a federal cost-saving statute enacted in 1980 to combat increasing costs of Medicare, the MSP makes the government a secondary payer when a Medicare recipient has another source of primary insurance coverage. 42 USCA §1395y(b)(2).

In 2003, the MSP was expanded to include other responsible sources, such as tortfeasors as primary payers responsible for payment of the beneficiary's medical expenses.

This statute implicates payment for past medical expenses (those incurred prior to a settlement, judgment or award) and future medical expenses (those incurred after a settlement, judgment, or award).

Past Medical: Conditional Payments

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Statutory Authority: 42 USC §1395y(b)(2)

Medicare has been given authority to make payment for an item or service if a primary plan has not made or cannot reasonably be expected to make payment promptly. 42 USC §1395y(b)(2)(B)(i).

These payments are conditioned on reimbursement from "a primary plan, and an entity that receives payment from a primary plan . . . if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." 42 USC §1395y(b)(2)(B)(ii).

A primary plan's responsibility for payment may be demonstrated by "a judgment, a payment conditioned upon the recipient's compromise, waiver or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means." 42 USC §1395y(b)(2)(B)(ii).

Statutory Authority: 42 USC §1395y(b)(2)-Who Can Sue

Medicare may bring an action against “any or all entities that are or were required or responsible (directly as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment under a primary plan.” 42 USC §1395y(b)(2)(B)(iii).

In addition to a direct cause of action, Medicare is subrogated to any right of an individual or other entity to payment under a primary plan. 42 USC §1395y(b)(2)(B)(iv).

Statutory Authority: 42 USC §1395y(b)(3)-Who Can Sue

Additionally, “There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement). “ 42 USC §1395y(b)(3)(A).

Statutory Authority: Double Damages

Medicare may collect double damages. 42 USC §1395y(b)(2)(B)(iii).

Statutory Authority: Statute of Limitations

Medicare has three years from the date of the receipt of notice of a settlement, judgment, award, or other payment made to bring an action for reimbursement. 42 USC §1395y(b)(2)(B)(iii).

Recovery of Conditional Payments 42 C.F.R §411.24

CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.

Amount of recovery is the lesser of (a) the amount of the Medicare primary payment or (b) the full primary payment amount that the primary payer is obligated to pay

If legal action is necessary to recover from the primary payer, CMS may recover twice the amount of the Medicare primary payment.

Recovery of Conditional Payments 42 C.F.R §411.24

CMS has a right of action to recover its payment from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.

Must reimburse Medicare within 60 days. Interest may accrue from the date when notice or other information is received by CMS that payment has been or could be made under a primary plan.

If Medicare makes a conditional payment with respect to services for which the beneficiary has not filed a proper claim with a primary payer, and Medicare is unable to recover from the primary payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

Recovery of Conditional Payments 42 C.F.R §411.24

Amount of Medicare recovery when a primary payment is made as a result of a judgment or settlement. 42 C.F.R §411.24.37

Recovery against the party that received payment:

- General rule: Medicare reduces recovery for procurement costs if costs incurred because the claim was disputed and the costs are borne against the party against CMS seeks to recover.
- Special rule: If CMS must file suit because the party that received payment opposes CMS's recovery, the recovery is the lower of (a) the Medicare payment or (b) the total judgment or settlement amount, minus the party's total procurement cost.

Limitations on Medicare Payments for Services Covered by Workers' Compensation. 42 C.F.R. §411.40-47.

- Medicare does not pay for any service which payment has been made or can reasonably be expected to be made under a workers' compensation law or plan. 42 C.F.R §411.24.40
- Beneficiary is responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under workers' compensation. 42 C.F.R §411.24.43(a)

Limitations on Medicare Payments for Services Covered by Workers' Compensation. 42 C.F.R. §411.40-47.

If a claim is denied for reasons other than not being a proper claim, Medicare will pay for the services if covered under Medicare. 42 C.F.R §411.24.43(d)

A conditional payment may be made if either:

- The beneficiary has filed a proper claim, but the intermediary or carrier determines that the workers' compensation carrier will not pay promptly. This includes cases in which a workers' compensation carrier has denied a claim.
- The beneficiary, because of physical or mental incapacity, failed to file a proper claim.

Medicare Advantage Plans

In 2021, more than 26 million people are enrolled in a Medicare Advantage plan, accounting for 42 percent of the total Medicare population. The percentage of enrollees in Medicare Advantage Programs has risen every year since 2004.

Medicare Advantage Plans

In re Avandia Marketing, Sales Practices, and Products Liability Litigation, 685 F.3d 353 (3rd Cir. 2012)

Humana Medical Plan, Inc. v. Western Heritage Ins. Co., 832 F.3d 1229 (11th Cir 2016).

MSP Recovery, LLC v. Allstate Ins. Co., 835 F.3d 1351 (11th Cir. 2016).

Medicare Advantage Plans

The PAID Act was signed into law on December 11, 2020.

Beginning December 11, 2021, CMS will provide up to three years of beneficiary enrollment data for Part C and Part D plans through Section 111 query process.

Future Medical: Medicare Set-Asides

FUTURE MEDICAL: MSA's

Statutory Authority

- Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made" by a primary payer. 42 USCA §1395y(b)(2).

Protecting Medicare's Interests

- Any claimant who receives a WC settlement, judgment, or award that includes an amount for future medical expenses must take Medicare's interests with respect to future medicals into account.
  - If Medicare's interests are not considered, CMS has a priority right of recovery against any entity that received a portion of a third-party payment either directly or indirectly. Medicare may also refuse to pay for future medical expenses related to the WC injury until the entire settlement is exhausted.

CMS Publications

CMS states establishing a WCMSA is not necessary when ALL of the following are true:

- The employee is only being compensated for past medical expenses;
- There is no evidence that the individual is attempting to maximize the other aspects of the settlement; AND
- The employee's treating physicians conclude in writing that to a reasonable degree of medical certainty the individual will no longer require any Medicare-covered treatments related to the WC injury.

Zero Dollar MSA

- The claim is denied; and
- No payments of any kind (medical or indemnity) have ever been made.
  - If you plan to submit to CMS be sure to submit before any settlement proceeds are distributed.

Considerations when Creating an MSA

Lump Sum vs. Structured Settlement

- Lump Sum – doesn't require additional management, preferable when set aside amount is minimal.
- Structured Settlement – Less money up front, additional savings possible if Claimant doesn't live to life expectancy

Prescription Costs

- Dependent on fluctuating costs and prescriptions at time of MSA creation
- Therefore, it is important to consider timing of MSA because CMS will look at current prescription costs to project future expenses

Uncovered Expenses

- Keep in mind MSA's only cover Medicare covered expenses. Therefore, if Claimant requires future medical treatment not covered by Medicare it will need to be addressed separately. (Ex: Certain home health care expenses, hearing aids, medical mileage etc.)

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